Texas Department of Aging
and Disability Services

Regulatory Services (E-342)
P.O. Box 149030
Austin, TX 78714-9030
(512) 438-2630 FAX: (512) 438-2727

Form 3716
March 2009

Application to Increase Licensed Capacity of a Long-Term Care Facility

Part I – General Information

1. Facility Name	Facility ID No.	Telephone No. (inc. A/C) ( )
2. Physical Address (Street, City, State, ZIP)		County
3. Facility Mailing Address (if different from Physical Address)		

4. Type of Facility

☐ **Nursing Facility** ⇨ ☐ **All Private Pay** ☐ **Certified**	☐ **Assisted Living Facility (Type A)** ⇨ ☐ **Small (16 or less)** ☐ **Large (17 or more)**
☐ **ICF/IID Facility** ⇨ ☐ **Small** ☐ **Large**	☐ **Assisted Living Facility (Type B)** ⇨ ☐ **Small (16 or less)** ☐ **Large (17 or more)**
☐ **Facility for ICF/IID** ⇨ ☐ **ICF/IID**	☐ **Adult Day Care Facility** ⇨ ☐ **Private Pay** ☐ **DADS DAHS** ☐ **Other**

5. Requested Capacity and Amount of Fee
In accordance with 40 Texas Administrative Code §92.4 (Assisted Living Facilities), the fee has increased.

Licensed Capacity	Additional Capacity Requested	Fee Enclosed (see Fee Schedule below) *$	***Make check or money order payable to Texas Department of Aging and Disability Services**

Fee Schedule	**Nursing Facilities:** ⇨ **$10.00 per bed**	**ICF/IID Facilities, Facilities for ICF/IID:** ⇨ **$5.00 per bed**	**Assisted Living Facilities:** ⇨ **$10.00 per bed**	**Adult Day Care:** ⇨ **No Fee**

6. Nursing Facility Administrator or Administrator of Facility Serving Persons with an Intellectual Disability/Related Conditions

(Mr., Ms., Dr.)	Name (First, MI, Last) – If nursing facility, attach copy of administrator's current renewal card.	Social Security No.	License No. (if applicable)

Part II – Local Authority Approvals

7. Fire authority must sign below or provide separate written approval.

To the best of my knowledge, at the time of the inspection, the facility meets all local fire safety requirements.

_____ _____
Signature – Fire Marshal Date

8. Include a copy of the letter to the local health authority informing it of a change in the facility's license.

Part III – Owner/Applicant

The facts set forth in the foregoing application are true to the best of my knowledge. I understand that submission of false information in this application will constitute grounds for denial, suspension or revocation of my state license.

_____ _____
Signature – Owner/Applicant (or Authorized Representative) Date

Sworn to and subscribed before me this _____ day of _____, 2_____.

_____
Signature – Notary Public

Remittance No. and Date

For DADS Use Only

Application Approval Date	Reviewer